NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 43. BOARD OF OCCUPATIONAL THERAPY EXAMINERS

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**
   R4-43-101 — Amend

2. **The specific authority for the rulemaking, including both the authorized statute (general) and the statutes the rules are implementing (specific):**
   Authorizing statute: A.R.S. § 32-3404

   Implementing statutes: A.R.S. §§ 32-3404(A)(4) and 32-3441(D)

3. **The effective date of the rules:**
   November 6, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**
   Notice of Rulemaking Docket Opening: 4 A.A.R. 4823, November 29, 1996.

   Notice of Proposed Rulemaking: 3 A.A.R. 1172, May 2, 1997.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Kenneth D. Fink, Executive Director
Address:	Board of Occupational Therapy Examiners 1400 West Washington, Suite 420 Phoenix, Arizona 85007
Telephone:	(602) 542-5300
Fax:	(602) 542-5469

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
   a. The Board recognizes the requirement to define certain terms within their statutes as they relate to the regulation of the Arizona Occupational Therapy profession and the mandate to safeguard the health, safety, and welfare of the public. The proposed rulemaking was introduced prior to the enactment of recent statute changes becoming effective on and after July 31, 1997. The enacted statutes becoming effective on and after July 31, 1997, are attached. The enacted changes are shown in capital letters and the deleted language is stricken (lined through). Some of the initially proposed rulemaking changes were incorporated within the statutes and therefore, removed from the rulemaking.

   b. The Occupational Therapy Assistant has been a license of this Board since the Board of Occupational Therapy Examiners law began. However, historically the Occupational Therapy Assistant has been omitted from some of the statutes and rules as a regulated licensee. Arizona Revised Statues § 32-3401(7) identifies the Occupational Therapy Assistant as requiring a license and A.R.S. § 32-3441(D) authorizes the Board to adopt rules reasonably related to sound patient care governing the supervision of the licensed Occupational Therapy Assistant. The Occupational Therapy Assistant was added into amended rule R4-43-101(A).

   c. A.R.S. § 32-3423(1) mandates that an applicant be of good moral character and has not been convicted of a crime of moral turpitude. Good Moral Character is defined in R4-43-101(B). The rule is amended to read "Good Moral Character" means the person has not been convicted of a felony or a misdemeanor within 5 years prior to application and has never been convicted of a felony or misdemeanor involving moral turpitude.

   d. R4-43-101(C) is modified to remove the words "Registered" and "Certified" and adds the "National Board for Certification in Occupational Therapy, Incorporated" as the certifying entity for current applicants and future licensees. The American Occupational Therapy Certification Board must remain shown in the rule because previous licensees were certified by the Board.

e. A.R.S. § 32-3401(9)(f) reads "immorality or misconduct that tends to discredit the occupational therapy profession," which means a lot of different things to many different people. The subsection pleads for definition as it relates to the regulation of the Arizona Occupational Therapy industry. Without a written definition, the intent of the subsection is basically meaningless and unknown to licensees, unlicensed people and is perhaps unenforceable by this Board.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
Small businesses and consumers will benefit from these rule changes because they will make it much clearer and understandable those terms that were not previously defined or fully defined. The written definitions are expected to help eliminate time consuming telephone calls to the Board in order to inquire the meaning of certain terms used in the statutes and rules. Additionally, having a clear understanding of the terms will help to eliminate any possible investigation costs to the Board and costs to small businesses in order to respond to possible investigation.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules:**
a. Proposed rule amendments, R4-43-101(A), (B), and, (C), shown in the Notice of Proposed Rulemaking, were deleted because these changes were incorporated into the enacted statutes effective on and after July 31, 1997, (copy enclosed).

b. The licensee "Occupational Therapy Assistant" was added to the proposed rule amendment R4-43-101(D). The adopted rule reads "Facility of Practice" means the principal location of each agency or organization for which the occupational therapist or occupational therapy assistant practices occupational therapy.

c. The words "prior to application" were removed from R4-43-101(B) because the phrase "has never been convicted of a felony or misdemeanor involving moral turpitude" applies to all periods of licensure and not just to periods prior to application.

d. In amended R4-43-101(C) the words "Registered" and "Certified" are removed because this Board does not require continued certification with either the American Occupational Therapy Certification Board or the National Board for Certification in Occupational Therapy, Incorporated once licensed by this Board. The National Board for Certification in Occupational Therapy, Incorporated assumed the duties of the American Occupational Therapy Certification Board for current applicants and future licensees.

e. Some of the original language within amended R4-43-101(D) was either deleted or shortened because some parts of the proposed rule were included in the enacted legislation effective on and after July 31, 1997, (copy enclosed).

10. **A summary of the principal comments and the agency response to them:**
There were no comments submitted concerning this proposed rulemaking.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class or rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
Not applicable.

13. **Was this rule previously adopted as an emergency rule?**
No.

14. **The full text of the rules follows:**

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 43. BOARD OF OCCUPATIONAL THERAPY EXAMINERS

ARTICLE 1. GENERAL PROVISIONS

Section
R4-43-101. Definitions

ARTICLE 1. GENERAL PROVISIONS

R4-43-101. Definitions

A. "Facility of Practice" means the principal location of each agency or organization for which the occupationl therapist or occupational therapy assistant practices occupational therapy.

B. "Good Moral Character" means the person has not been convicted of a felony or a misdemeanor within 5 years prior to application and has never been convicted of a felony or misdemeanor involving moral turpitude ~~prior to application~~.

C. "Health Care Professional" means any person who is certified as an Occupational Therapist ~~Registered~~ or ~~a Certified~~ an Occupational Therapy Assistant by the American Occupational Therapy Certification Board or the National Board for Certification in Occupational Therapy, Incorporated or any health care professional duly licensed pursuant to Title 32 of the Arizona Revised Statutes or the equivalent if licensed outside of Arizona.

D. "Immorality or misconduct that tends to discredit the occupational therapy profession" means:

1. Engaging in false advertising regarding occupational therapy services.
2. Engaging in assault and battery of a patient or client, or other person, with whom the licensee has a professional relationship.

3. Engaging in or attempting to falsify patient or client documentation or reports or intentionally making false reports.
4. Failing to provide appropriate supervision of occupational therapy assistants or unlicensed personnel practicing or performing occupational therapy.
5. Failing to provide a comprehensive occupational therapy service that is compatible with current research and within an ethical and professional framework or provide professional occupational therapy services based upon the evaluation of the patient or client needs and appropriate treatment procedures.
6. Failing or refusing to document or maintain adequate patient treatment records or prepare patient or client reports within 30 days of service or treatment.
7. Failing to renew a license while continuing to practice occupational therapy.
8. Falsely or fraudulently claiming to have performed a professional service, charging for a service, or representing a service as the licensees own when the licensee has not rendered the service or assumed supervisory responsibility for the service.
9. Obtaining a fee by fraud, misrepresentation or offering to refer or referring a patient or client for a fee or other compensation from a 3rd party.
10. Sexually inappropriate conduct with a current client or patient or with a former client or patient within 6 months after the cessation or termination of treatment.
11. Signing a blank undated or unprepared prescription form.
12. Using fraud, misrepresentation or deception in assisting another person to obtain or attempt to obtain an occupational therapist or occupational therapy assistant license.
13. Violation of any federal or state law or administrative rules and regulations applicable to the practice of occupational therapy.
14. Violating the rules and statutes involving the training of unlicensed personnel assisting with the practice of occupational therapy or requiring an unlicensed person to provide occupational therapy services for which they have not been trained.

~~D.~~ E. "Licensee" means a person licensed by the state as an occupational therapist or an occupational therapy assistant.

~~E.~~ F. "Occupational therapy aide" means a person not licensed pursuant to the statutes and rules applicable to the practice of occupational therapy, who works under the direct supervision of a licensed occupational therapist, who assists in the practice of occupational therapy and whose activities require an understanding of occupational therapy, but do not require professional or advanced training in the basic anatomical, biological, psychological and social sciences involved in the practice of occupational therapy.

~~F.~~ G. "Party" shall be defined as provided in A.R.S. § 41-1001.

~~G.~~ H. "Physically Present" means personally present to observe the practice of occupational therapy.

~~H.~~ I. "Premise" means the building and the surrounding property in which the occupational therapy is practiced.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

R9-22-1001	Repeal
R9-22-1001	New Section
R9-22-1002	Repeal
R9-22-1002	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2903.01(H).

   Implementing statute: A.R.S. §§ 36-2903(C)(10), 36-2903(G), 36-2903.01(M) and (S), and 36-2915.

3. **The effective date of the rules:**

   November 7, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Docket Opening: 2 A.A.R. 2053, May 24, 1996

   Notice of Proposed Rulemaking: 2 A.A.R. 3124, June 14, 1996

   Notice of Supplemental Rulemaking: 2 A.A.R. 4868, December 6, 1996

   Notice of Public Hearing: 3 A.A.R. 2035, August 1, 1997

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson

   Address: AHCCCS

801 East Jefferson, MD 4200
Phoenix, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

Changes are made to 2 rules (R9-22-1001 and R9-22-1002) in 9 A.A.C. 22, Article 10, 1st-and 3rd-Party Liability to provide clarity regarding the process that has been in the agency's policies. In addition, changes are made to terminology used in 1st- and 3rd-party liability activities. The changes are designed to streamline the Article and make it more easily understood by consumers and other entities involved with 1st-and 3rd-party cost avoidance and recovery activities. Clarification and changes are also provided regarding notification requirements for counties, hospitals and contractors, providers, nonproviders and noncontracting providers.

Following is a description of the changes:

R9-22-1001, 3rd-party liability and coordination of benefits - Repealed the existing rule and added a new Section entitled "1st- and 3rd-Party Liability and Coordination of Benefits".

• Added definitions for "1st- party liability" and "cost avoidance".

• Added language requiring AHCCCS members and eligible persons to assist in identifying parties who may be liable to pay for AHCCCS-covered services. 42 CFR 433.145 requires Medicaid applicants to cooperate in identifying and providing information unless the individual establishes good cause for not cooperating.

• Added clarification regarding the process contractors use for cost avoidance activities.

R9-22-1002, 3rd-party liability monitoring and compliance - Repealed the existing rule and added a new Section entitled "1st- and 3rd-party Liability Monitoring and Compliance".

• Amended the terminology used in the list of 1st-and 3rd-party sources to reflect language used in the State Medicaid Manual (SMM). The SMM is the official medium by which the Health Care Financing Administration (HCFA), the federal government entity overseeing Medicaid, issues mandatory, advisory, and optional Medicaid policies and procedures to State Medicaid agencies such as AHCCCS.

• Extended the 2 time-frames during which the Administration must be notified to preserve its lien rights from:

• 5 to 30 days from the date of service for contractors, providers, nonproviders, and noncontracting providers; and

• 15 to 30 days from date of discharge for hospitals.

• Deletes language regarding forfeiture of right to reimbursement for contractors, providers and nonproviders who fail to meet notification time-frames and requirements.

• Clarified that 2 1st-and 3rd-party sources (adoption related payments and long-term care insurance) currently pursued in practice are listed in rule.

• Expanded the parties and the notification time-frames for health insurance information to AHCCCS from contractors (as specified in contract) to contractors, providers and noncontracting providers and from within 10 days of receipt of health insurance information (in contract) to within 30 days of receipt of health insurance information.

• Changes the notification requirement that policy number beginning and end dates be submitted to "if available".

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

It is anticipated that there will be a nominal economic impact upon, and benefit to, the following parties as a result of the increased clarity and conciseness of the rule language:

• AHCCCS;

• The AHCCCS TPL contractor;

• AHCCCS contractors;

• AHCCCS providers, nonproviders and noncontracting providers

• Hospitals; and

• AHCCCS eligible persons and members.

The following entities were considered but will not be affected by the changes:

• Taxpayers;

• The larger business community, except for the AHCCCS TPL contractor, AHCCCS contractors and providers which will benefit from the changes;

Political subdivisions, such as cities or counties.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
The changes between the proposed rules and the final rules are minimal and include:

• Updated citations;

• Grammatical, verb tense, and punctuation changes throughout;

• Added "or other coverage" and changed "expenses" to "services" in R9-22-1001(A)(1).

• Added "reimbursement" to R9-22-1001(C).

• Added "rate less any amount paid by the 1st- and 3rd-party, and meet the requirements in R9-22-1001(C)(5).

• Deleted "acute", "care", and "and" so that the last line reads "to pay for covered services." in R9-22-1001(D)

• Deleted "deferred liability" in R9-22-1001(E)(5).

• Extended the 2 time-frames in R9-22-1002(D) during which the Administration must be notified to preserve its lien rights from:

• 15 to 30 days from date of discharge for hospitals; and

• 5 to 30 days from the date of service for contractors, providers, nonproviders, and noncontracting providers.

• Changed the notification requirement that policy number beginning and end dates be submitted to "if available" in R9-22-1002(F)(5) and (6).

• Deleted language regarding forfeiture of right to reimbursement for contractors, providers and nonproviders who fail to meet notification time-frames and requirements in R9-22-1002(G).

10. **A summary of the principal comments and the agency response to them:**
The Administration received formal comments from 2 organizations (Arizona Medical Association and Law Office of Barclay & Goering, P.C.). Their principal comments can be categorized into 4 areas: 1) the rule package should be amended to apply only to providers who have contracts with the AHCCCS System; 2) the time-frames are very strict; 3) the demand for detailed information is difficult within the required time-frames; and 4) forfeiture of payments should apply only to providers of the System.

The Administration believes we have the statutory authority to require contractors, providers, nonproviders and noncontracting providers to identify, notify and collect 1st- and 3rd- party resources. However, we made changes in time-frames (R9-22-1002(D)(2)(3) and R9-22-1002(F)); the amount of information they need to report (R9-22-1002(F)(5)(6); and deleted the language on forfeiture (R9-22-1002(G)).

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **Was this rule previously adopted as an emergency rule?**
Not applicable.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 10. ~~THIRD-PARTY LIABILITY~~ 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

Section

R9-22-1001. ~~Third-party liability and coordination of benefits~~ 1st-and 3rd-Party Liability and Coordination of Benefits

R9-22-1002. ~~Third-party Monitoring and Compliance~~ 1st-and 3rd-Party Liability Monitoring and Compliance

ARTICLE 10. ~~THIRD-PARTY LIABILITY~~ 1ST-AND-3RD PARTY LIABILITY AND RECOVERIES

R9-22-1001. ~~Third-party liability and coordination of bene-~~

~~fits~~ 1st-and 3rd-Party Liability and Coordination of Benefits

~~A. Payor of last resort. AHCCCS shall be used as a source of payment for covered services only after all other sources of payment for members and eligible persons receiving care have been used. AHCCCS shall act only as a payor of last resort unless specifically prohibited by applicable federal law.~~

~~B. Reasonable efforts. The Administration, providers, nonproviders, eligible nonenrolled persons and members shall take reasonable measures to identify and recover from legally liable third party resources. Providers include prepaid capitated contractors.~~

~~C. Collections. Contractors are responsible for identifying and pursuing collection of reimbursement from all probable sources of third party liability, except for underinsured and uninsured motorists insurance, third party liability insurance and tort feasors. Contractors are responsible for identifying and notifying the Administration in accordance with subsection (D) of R9-22-1002 of the potential liability of underinsured and uninsured motorist insurance, third party liability insurance and tort feasors. The Administration shall coordinate and pursue collection from underinsured and uninsured motorist insurance, third party liability insurance and tort feasors in cases of probable third party liability. Contractors shall cooperate with the Administration in its collection efforts.~~

~~D. Duplication of benefits. Payments made for covered services by AHCCCS shall not duplicate benefits otherwise available from probable third party payors. Payments by AHCCCS for covered services may supplement payment or benefits from third parties to the extent authorized by these rules or applicable contracts.~~

~~E. Recovery; prepaid capitated contractors. A contractor may retain up to 100% of its third party collections provided that:~~

~~1. Total payments received do not exceed the total amount of the contractor's financial liability for the member;~~

~~2. AHCCCS fee-for-service, deferred liability and reinsurance benefits have not duplicated the recovery;~~

~~3. Such recovery is not prohibited by federal or state law; and~~

~~4. The payments collected are reflected in reduced capitation rates. The Administration may require a contractor to reimburse the Administration up to 100% of third party payments collected which are not reflected in reduced capitation rates.~~

~~F. Recovery; Administration. The Administration may retain its third party collections up to 100% of fee-for-service, deferred liability and reinsurance payments.~~

A. Definitions. In this Section, the following definitions apply:

1. "1st-party liability" means the resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Administration, a member, or eligible person.
2. "Cost avoidance" means avoiding payment of claims when 1st- or 3rd-party payment sources are available.

B. General provisions. The System shall be the payor of last resort, unless specifically prohibited by applicable state or federal law. The Administration may subcontract distinct administrative functions as permitted by A.R.S. §§ 36-2903(D) and 36-2915(B).

C. Cost avoidance. The System shall cost avoid all claims or services that are subject to 1st- or 3rd-party liability source, and may deny a service to a member or eligible person if it knows that a 1st or 3rd party will provide the service. The requirement to cost avoid applies to all AHCCCS-covered services, unless otherwise specified in this Section.

1. Responsible parties. The following parties shall take reasonable measures to identify legally liable 1st- or 3rd-party sources:
   a. Administration,
   b. Contractor,
   c. Provider,
   d. Nonprovider,
   e. Noncontracting provider,
   f. Member, and
   g. Eligible person.
2. Coordination of benefits. If a contractor does not know whether a particular service is covered by a 1st-and 3rd-party insurer, and the service is medically necessary, the contractor shall contact the 1st and 3rd party, and determine whether the service is covered rather than requiring the member or eligible person to contact the 1st or 3rd party. If the contractor knows that the 1st-and 3rd-party insurer will neither pay for nor provide the covered service, and the service is medically necessary, the contractor shall neither deny the service nor require a written denial letter.
3. Copayment, coinsurance, deductible. If a 1st- or 3rd-party insurer (other than Medicare) requires a member or eligible person to pay any copayment, coinsurance, or deductible, the contractor must decide whether it is more cost effective to provide the service:
   a. Within its network for continuity of care; or
   b. Outside its network for continuity of care under the following conditions:
      i. Advance payments. If an insurer requires payment in advance of a copayment, coinsurance, or deductible, the contractor shall make the payment in advance for the member or eligible person.
      ii. Limitation of copayment, coinsurance, and deductible amounts. A contractor that meets the requirements in subsection (C)(5) is not responsible for paying a copayment, coinsurance, or deductible that is in excess of what the contractor would have paid for the entire service, per a written contract with the provider performing the service, or the AHCCCS fee-for-service rate minus any amount paid by the 1st and 3rd party.
4. Exceptions. A contractor shall provide the following services, and then coordinate payment with a 1st- and 3rd-party payor:
   a. Emergency service;
   b. Medically necessary transportation service. If a contractor approves a covered service out of the contractor's network, the contractor shall provide all medically necessary transportation, so 1st- and 3rd-party benefits can be received.
5. Medically necessary service. A contractor shall ensure that its cost avoidance efforts do not prevent an eligible person or member from receiving a medically necessary service, and that the eligible person or member is not required to pay any copayment, coinsurance, or deductible for use of the other insurer's provider;
6. Pre-natal and preventive services. The Administration may require a contractor to provide pre-natal and pre-

ventive pediatric services, and then coordinate payment with a liable 1st or 3rd party.

D. Member or eligible person participation. A member or an eligible person shall cooperate in identifying potentially liable 1st or 3rd parties and assist the Administration, contractor, provider, nonprovider, or noncontracting provider in pursuing any 1st or 3rd party who may be liable to pay for covered services.

E. Collections.

1. The following parties shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability:
   a. Provider,
   b. Nonprovider, and
   c. Noncontracting provider.
2. The following parties shall pursue collection or reimbursement from all potential sources of 1st- or 3rd-party liability:
   a. The Administration,
   b. Provider,
   c. Nonprovider, and
   d. Noncontracting provider.
3. Contractors shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability and pursue collection or reimbursement according to R9-22-1002(B).
4. Recoveries: Contractor. A contractor may retain up to 100% of its 1st- and 3rd-party collections if:
   a. Total payments received do not exceed the total amount of the contractor's financial liability for the member. Payments in excess of the contractor's liability shall be reimbursed as described in 42 CFR 433.154;
   b. AHCCCS fee-for-service, reinsurance benefits or both have not duplicated the recovery. Any duplicated benefits received shall be reimbursed to the Administration. Payments by the Administration for covered services may supplement payment or benefits from 1st or 3rd parties to the extent authorized by this Chapter or applicable contracts;
   c. The recovery is not prohibited by federal or state law; and
   d. The payments collected are reflected in reduced capitation rates. The Administration may require a contractor to reimburse the Administration up to 100% of collected 1st- and 3rd-party payments that are not reflected in reduced capitation rates.
5. Recoveries: Administration. The Administration may retain its 1st- and 3rd-party collections up to 100% of fee-for-service, reinsurance payments, administrative costs, capitation payments, Medicare Part A and B premium payments, and any other payments made by the System. The funds collected shall be deposited in the AHCCCS fund.

R9-22-1002. ~~Third-party Liability Monitoring and Compliance~~ 1st-and 3rd-Party Liability Monitoring and Compliance

~~A. Categories of third-party liability. The Administration shall monitor third-party payments to a provider or nonprovider, which may include but are not limited to payments by or for:~~
~~1. Workmen's compensation,~~
~~2. Disability insurance,~~
~~3. A hospital and medical service corporation,~~
~~4. A health care services organization or other health or medical insurance plan,~~
~~5. Standard health insurance,~~
~~6. Medicare and other governmental payors,~~
~~7. Medical payments insurance for accidents,~~
~~8. Underinsured or uninsured motorist insurance, third party liability insurance or tort feasors.~~

~~B. Contractor responsibility. The contractor shall be responsible for recovering third party payments from the sources set forth in subsection (A), paragraphs (1) through (7).~~

~~C. Monitoring. The Administration shall determine whether a provider or nonprovider is in compliance with the requirements set forth in this Article by inspecting source documents for:~~
~~1. Verifiability and reliability,~~
~~2. Appropriateness of recovery attempt,~~
~~3. Timeliness of billing,~~
~~4. Accounting for reimbursements,~~
~~5. Auditing of receipts, and~~
~~6. Other monitoring deemed necessary by the Administration.~~

~~D. Notification for perfection, recording and assignment of AHCCCS liens.~~
~~1. County requirements. The county of residence shall notify the Administration pursuant to subsection (E) not later than five days after it files a lien pursuant to A.R.S. § 11-291 for charges for hospital or medical services provided to an injured person who is determined AHCCCS eligible, so that the Administration may preserve its lien rights pursuant to A.R.S. § 36-2915.~~
~~2. Hospital requirements. Hospitals providing emergency or urgent medical services to an eligible nonenrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party shall notify the Administration pursuant to subsection (E) not later than 15 days after discharge. A hospital also may satisfy the requirement of this paragraph by mailing to the Administration a copy of the lien it proposes to record or has recorded pursuant to A.R.S. § 33-932 not later than 15 days after discharge.~~
~~3. Provider and nonprovider requirements. Providers and nonproviders other than hospitals rendering medical services to an eligible nonenrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party shall notify the Administration pursuant to subsection (E) not later than five days after providing such services.~~

~~E. Notice requirements. Notice requirements shall be satisfied when all of the following information is mailed to the Administration:~~
~~1. Name of provider or nonprovider;~~
~~2. Address of provider or nonprovider;~~
~~3. Name of patient;~~
~~4. Patient's Social Security Number or AHCCCS identification number;~~
~~5. Address of patient;~~
~~6. Date of patient's admission;~~
~~7. Amount estimated to be due for care of patient;~~
~~8. Date of patient's discharge;~~
~~9. Name of county in which injuries were sustained; and~~
~~10. Names and addresses of all persons, firms or corporations and their insurance carriers claimed by the patient or the patient's legal representative to be liable for damages.~~

~~F. Sanctions. Providers or nonproviders who fail to meet the notice requirements set forth in this Section shall forfeit their right to reimbursement, including fee-for-service, deferred liability and reinsurance, from the Administration for ser-~~

~~vices provided to eligible nonenrolled persons or members, unless the provider or nonprovider demonstrates good cause for such failure. Good cause means a cause that was not within the provider's or nonprovider's control.~~

A. 1st- or 3rd-party liability sources. The Administration shall monitor 1st- or 3rd-party liability payments to a contractor, provider, nonprovider, or noncontracting provider, which may include but are not limited to payments by or for:
   1. Private health insurance;
   2. Employment related disability and health insurance;
   3. Long-term care insurance;
   4. Other federal programs not excluded by statute;
   5. Court ordered or non-court ordered medical support from an absent parent;
   6. State worker's compensation;
   7. Automobile insurance, including underinsured and uninsured motorists insurance;
   8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
   9. First-party probate estate recovery;
   10. Adoption related payment; and
   11. Tortfeasor.

B. Contractor responsibility. A contractor shall:
   1. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(1) through (A)(5); and
   2. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(6) through (A)(11), when directed by the Administration.

C. Monitoring. The Administration shall determine whether a contractor, provider, nonprovider, or noncontracting provider is in compliance with the requirements in this Article by inspecting claim submissions and payment documentation for cost avoidance and recovery activities.

D. Notification for perfection, recording, and assignment of AHCCCS liens.
   1. County requirements. The county of residence shall notify the Administration according to subsection (E) within 30 days after providing services according to A.R.S. § 11-291 of charges for hospital or medical services provided to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party, so the Administration may preserve its lien rights according to A.R.S. § 36-2915.
   2. Hospital requirements. Hospitals providing emergency or urgent medical services to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party shall notify the Administration according to subsection (E) within 30 days after discharge. A hospital may satisfy the requirement of this subsection also by mailing to the Administration a copy of the lien it proposes to record or has recorded according to A.R.S. § 33-932 within 30 days after discharge.
   3. Contractor, provider, nonprovider, and noncontracting provider requirements. A contractor, provider, nonprovider, or noncontracting provider, other than a hospital, rendering medical services to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party shall notify the Administration according to subsection (E) within 30 days after providing the services.

E. Notification information for liens. To satisfy notification requirements, all of the following information shall be mailed to the Administration:
   1. Name of the contractor, provider, nonprovider, or noncontracting provider;
   2. Address of the contractor, provider, nonprovider, or noncontracting provider;
   3. Name of member or eligible person;
   4. Member's or eligible person's Social Security number or AHCCCS identification number;
   5. Address of member or eligible person;
   6. Date of member's or eligible person's admission;
   7. Amount estimated to be due for care of member or eligible person;
   8. Date of member's or eligible person's discharge;
   9. Name of county in which injuries were sustained; and
   10. Name and address of all persons, firms, and corporations and their insurance carriers claimed by the member, eligible person, or legal representative to be liable for damages.

F. Notification of health insurance information. A contractor, provider, nonprovider, or noncontracting provider shall provide notification of health insurance information to the Administration. To satisfy notification requirements, all of the following health insurance information shall be submitted to the Administration within 10 days of receipt of the health insurance information:
   1. Name of member or eligible person;
   2. Member's or eligible person's Social Security number or AHCCCS identification number;
   3. Insurance carrier name;
   4. Insurance carrier address;
   5. Policy number, if available;
   6. Policy begin and end dates, if available; and
   7. Insured's name and Social Security number.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-28-901	Amend
R9-28-902	Amend
R9-28-906	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2932(P)

   Implementing statute: A.R.S. §§ 36-2915, 36-2935, 36-2946, 36-2956

3. **The effective date of the rules:**

   November 7, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Rulemaking Docket Opening: 1 A.A.R. 2764, December 22, 1995

   Notice of Proposed Rulemaking: 3 A.A.R. 2019, August 1, 1997

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson

   Address: AHCCCS
   801 East Jefferson, MD4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   Changes are made to 3 rules (R9-28-901, R9-28-902 and R9-28-906) in Article 9 pertaining to 1st- and 3rd-party liability and coordination of benefits, monitoring, compliance and recoveries. The changes are designed to:

   • Comply with changes made to federal law; and

   • Align ALTCS rules with AHCCCS acute care rules and make the rules more user friendly.

   Following is a description of the changes:

   • R9-28-901, 3rd-Party Liability and Coordination of Benefits - Deleted current language and added language to align the rule with acute care rule R9-22-1001. This will clarify that the Administration may subcontract distinct administrative functions as permitted by A.R.S. §§ 36-2903(D) and 36-2915(B).

   • R9-28-902, 3rd-Party Liability Monitoring and Compliance - Deleted current language and added language to align the rule with acute care rule R9-22-1002. This will clarify that the notification time-frames for hospital, providers and noncontracting providers will be expanded from 5 to 30 days. This will also expand the parties and the notification time-frames for health insurance information to AHCCCS from contractors (as specified in contract) to contractors, providers and noncontracting providers and from within 10 days of receipt of health insurance information (in contract) to within 30 days of receipt of health insurance information. A further change will result in deletion of language regarding forfeiture of right to reimbursement for contractors, providers and nonproviders who fail to meet notification time-frames and requirements. The Administration amended the notification requirements for contractors, providers, and noncontracting providers. This amendment will require that contractors, providers, and noncontracting providers provide the policy number and the policy beginning and end dates, if available.

   • R9-28-906, Recoveries - Reduced, from 65 to 55 years, the minimum age of a member whose estate AHCCCS may recover from. This change allows AHCCCS to comply with the requirements in OBRA '93 that changed the age requirement to 55 years of age. The impact of this change is not measurable because cost and population numbers are not readily available. The administration also incorporated hardship criteria established by the state to comply with federal requirements and guidelines by clarifying that the agency may waive or compromise recovery of funds when the recovery would cause an undue hardship to the member's or eligible person's surviving heirs.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

   Although both of the following parties are expected to benefit from the changes which provide clarity and conciseness to the Article, it is anticipated that there will be a nominal impact on:

   • AHCCCS for costs that AHCCCS decides to waive or compromise when the recovery of funds would cause an undue hardship to a member's or eligible person's surviving heirs; and

   • A limited number of providers and noncontracting providers for changes regarding health insurance information notification requirements. However, some of the impact will be moderated by the extension of the notification time-frames from within 5 to within 30 days of health insurance information.

In addition, the following other parties will benefit from the changes which align ALTCS rules with AHCCCS acute care rules:

- The AHCCCS TPL contractor,
- ALTCS contractors, and
- The surviving heirs of ALTCS members or eligible persons.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

The changes between the proposed rules and the final rules are minimal and include:

- Updated citations;
- Grammatical, verb tense, and punctuation changes throughout; and
- Clarified language in R9-28-906, Recoveries.

10. **A summary of the principal comments and the agency response to them:**

The Administration received formal comments from 2 organizations (Arizona Medical Association and Law Office of Barclay & Goering, P.C.). They commented on R9-22-1001 and R9-22-1002, however, the comments also apply to this rulemaking package because the Administration cross references to R9-22-1001 and R9-22-1002. Their principal comments can be categorized into 4 areas: 1) these rule packages should be amended to apply only to providers who have contracts with the AHCCCS System; 2) the time-frames are very strict; 3) the demand for detailed information is difficult within the required time-frames; and 4) forfeiture of payments should apply only to providers of the System.

The Administration believes we have the statutory authority to require contractors, providers, nonproviders and noncontracting providers to identify, notify and collect 1st- and 3rd- party resources. However, we made changes in time-frames (R9-22-1002(D)(2)(3) and R9-22-1002(F)); the amount of information they need to report (R9-22-1002(F)(5)(6); and deleted the language on forfeiture (R9-22-1002(G)).

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

Not applicable

12. **Incorporations by reference and their location in the rules:**

42 U.S.C. § 1396(p), October 1, 1993, as incorporated in R9-28-906.

13. **Was this rule previously adopted as an emergency rule?**

No.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) LONG-TERM CARE SYSTEM

ARTICLE 9. ~~THIRD-PARTY LIABILITY~~ 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

Section

R9-28-901. ~~Third-party liability and coordination of benefits~~ 1st- and 3rd- Party Liability and Coordination of Benefits

R9-28-902. ~~Third-party Liability Monitoring and Compliance~~ 1st- and 3rd-Party Liability Monitoring and Compliance

R9-28-906. Recoveries

ARTICLE 9. ~~THIRD~~ 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-28-901. ~~Third-party liability and coordination of benefits~~ 1st- and 3rd-Party Liability and Coordination of Benefits

~~A. Payor of last resort. The ALTCS shall be used as a source of payment for covered services only after all other sources of payment for members and eligible persons receiving care have been used. The ALTCS shall act as a payor of last resort unless specifically prohibited by applicable state or federal law.~~

~~B. Reasonable efforts. The Administration, program contractors, providers, and noncontracting providers, eligible nonenrolled persons and members shall take reasonable measures to identify and receive from legally liable third party resources.~~

~~C. Member participation. It is the member's or eligible person's responsibility to cooperate, insofar as possible, to identify potentially liable third parties and to assist the program contractor, provider or noncontracting provider in pursuing any third party who may be liable to pay for ALTCS covered care and services.~~

~~D. Collections. Program contractors, providers and noncontracting providers are responsible for identifying and pursuing collection of reimbursement from all probable sources of third party liability, except for underinsured and uninsured motorist insurers, third party liability insurers and tort feasors. Program contractors are responsible for identifying and notifying the Administration in accordance with subsection (D) of R9-28-902 of the potential liability of underinsured and uninsured motorist insurers, third party liability insurers and tort feasors. The Administration shall coordinate and pursue collection from underinsured and uninsured motorist insurers, third party liability insurers and tort feasors in cases~~

~~of probable third-party liability. Program contractors shall cooperate with the Administration in its collection efforts.~~

~~E. Duplication of benefits. Payments made for covered services by ALTCS shall not duplicate benefits otherwise available from probable third-party payors. Payments by ALTCS for covered services may supplement payment or benefits from third parties to the extent authorized by this Chapter or applicable contracts.~~

~~F. Recovery for program contractors. A program contractor may retain up to 100% of its third-party collections provided that:~~

~~1. Total payments received do not exceed the total amount of the program contractor's financial liability for the member;~~

~~2. ALTCS fee-for-service, deferred liability and reinsurance benefits have not duplicated the recovery;~~

~~3. Such recovery is not prohibited by federal or state law;~~

~~4. The payments collected are reflected in capitation rates. The Administration may require a program contractor to reimburse the Administration up to 100% of third-party payments collected which are not reflected in capitation rates.~~

~~G. Recovery for the Administration. The Administration may retain its third-party collections up to 100% of capitation payments, fee-for-service and reinsurance payments. The funds collected shall be deposited in the ALTCS fund.~~

General Provisions. The provisions in R9-22-1001 apply to this Section.

R9-28-902. ~~Third-party~~ 1st- and 3rd-Party Liability Monitoring and Compliance

~~A. Categories of third-party liability. The Administration shall monitor third-party payments to a program contractor, provider or noncontracting provider, which may include payments by or for:~~

~~1. Workmen's compensation;~~

~~2. Disability insurance;~~

~~3. A hospital and medical service corporation;~~

~~4. A health care services organization or other health or medical or insurance plan;~~

~~5. Standard health insurance;~~

~~6. Medicare and other governmental payors;~~

~~7. Medical payments insurance for accidents;~~

~~8. Underinsured or uninsured motorist insurance, third-party liability insurance or tort feasors.~~

~~B. Monitoring. The Administration shall determine whether a program contractor, provider or noncontracting provider is in compliance with the requirements set forth in this Article by inspecting source documents for:~~

~~1. Verifiability and reliability;~~

~~2. Appropriateness of recovery attempt;~~

~~3. Timeliness of billing;~~

~~4. Accounting for reimbursements;~~

~~5. Auditing of receipts;~~

~~6. Other monitoring deemed necessary by the Administration.~~

~~C. Notification for perfection, recording and assignment of ALTCS liens:~~

~~1. County requirements. The county of residence shall notify the Administration pursuant to subsection (D) not later than five days after it files a lien pursuant to A.R.S. § 11-291 for charges for hospital, medical or ALTCS services provided to an injured person who is determined ALTCS eligible, so that the Administration may preserve its lien rights pursuant to A.R.S. § 36-2915, A.R.S. § 36-2935, or A.R.S. § 36-2956 or its claim rights pursuant to A.R.S. § 36-2935.~~

~~2. Hospital requirements. Hospitals providing emergency or urgent medical services to an eligible non-enrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party shall notify the Administration pursuant to subsection (D) not later than 15 days after discharge. A hospital may also satisfy the requirement of this Paragraph by mailing to the Administration a copy of the lien it proposes to record or has recorded pursuant to A.R.S. § 33-932 not later than 15 days after discharge.~~

~~3. Program contractors, provider and noncontracting provider requirement. Program contractors, providers and noncontracting providers other than hospitals rendering medical services to an eligible non-enrolled person or member for an injury or condition resulting from circumstances reflecting the probable liability of a third party shall notify the Administration pursuant to subsection (D) not later than five days after providing such services.~~

~~D. Notice requirements. Notice requirements shall be satisfied when all of the following information is mailed to the Administration:~~

~~1. Name of program contractor, provider or noncontracting provider;~~

~~2. Address of program contractor, provider or noncontracting provider;~~

~~3. Name of patient;~~

~~4. Patient's social security number or ALTCS identification number;~~

~~5. Address of patient;~~

~~6. Date of patient's admission;~~

~~7. Amount estimated to be due for care of patient;~~

~~8. Date of patient's discharge;~~

~~9. Name of county in which injuries were sustained; and~~

~~10. Names and addresses of all persons, firms or corporations and their insurance carriers claimed by the patient or the patient's legal representative to be liable for damages.~~

~~E. Sanctions. Program contractors, providers or noncontracting providers who fail to meet the notice requirements set forth in this Section shall forfeit their right to reimbursement, including fee-for-service, deferred liability and reinsurance, from the Administration for services provided to eligible non-enrolled persons or members, unless the program contractor, provider, or noncontracting provider demonstrates good cause for such failure.~~

General provisions. The provisions in R9-22-1002 apply to this Section.

R9-28-903. Reserved

R9-28-904. Reserved

R9-28-905. Reserved

R9-28-906. Recoveries

~~The Administration may recover funds for ALTCS benefits paid for an individual from:~~

~~1. The estate of a member who was 65 years of age or older when he received benefits; or~~

~~2. The estate or the property of a member pursuant to A.R.S. §§ 36-2935 and 36-2956 and 42 CFR 433.36, incorporated by reference herein and on file with the Office of the Secretary of State.~~

A. The Administration may recover funds paid for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance, deductibles, fee-for-service, and any other payments made by the Administration for a member or eligible person from:
   1. The estate of the member or eligible person who was 55 years of age or older when the member or eligible person received benefits; or
   2. The estate or the property of the member or eligible person according to A.R.S. §§ 36-2935 and 36-2956 and 42 U.S.C. 1396(p), October 1, 1993, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. The Administration may waive or compromise the recovery of funds when the recovery would cause an undue hardship to a surviving heir of the member or eligible person. In making the undue hardship decision, the Administration will consider the following:
   1. When estate assets include real property or both real and personal property. There is property in the estate, and the property is listed as residential property by the Arizona Department of Revenue or County Assessor's Office, and the heir:
      a. Owns a business that is located at the residential property, and
         i. The business was in operation at the residential property for at least 12 months preceding the death of the member or eligible person;
         ii. The business provides more than 50% of the heir's livelihood; and
         iii. The recovery of the property would result in the heir losing the heir's means of livelihood; or
      b. Currently resides in the residence, and
         i. Resided there at the time of the member's or eligible person's death;
         ii. Made the residence his or her primary residence for the 12 months immediately preceding the death of the member or eligible person; and
         iii. Owns no other residence.
   2. When the estate assets contain personal property only.
      a. The heir's annual gross income for the household size is within 100% of the Federal Poverty Level (FPL). New sources of income (for example, employment, Social Security), which may not have yet been received, will be included in determining the household's annual gross income; and
      b. The heir does not own a home, land, or other real property.

C. If the heir's circumstances meet the conditions in subsections (B)(1) or (B)(2), the Administration shall determine on a case-by-case basis, to what extent, if any, the claim will be compromised or waived. Factors in making this determination include:
   1. Financial and medical hardship to the heir if a compromise or waiver is not granted;
   2. Income of the heir and whether the heir's household's gross annual income is within 100% of the FPL;
   3. Resources of the surviving heir;
   4. Value and type of assets in the estate (real and personal);
   5. Amount of the Administration's claim against the estate; and
   6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

D. A promissory note and deed of trust may be required in cases where a claim against property is compromised or waived, and the heir resides in the residence, maintains a business at the residence, or otherwise relies on the residence for support and means of livelihood. Within 30 days of receiving an undue hardship decision notice from the Administration, the executor of the estate or heir shall secure a promissory note and deed of trust, and provide certified copies to the Administration. The heir shall bear the costs for securing these documents.